PASRR LEVEL II INDEPENDENT BEHAVIORAL HEALTH COMPREHENSIVE EVALUATION

DEMOGRAPHIC INFORMATION

Assessment Date				**Medicaid Number:**		
Recipient Name: (first, middle, last)						**Bayou Health Plan:**
Age:	DOB:	Ethnicity:	Gender:	Gender Expression:	Marital Status:	SSN:
LOCUS: (date and score)				**PRIMARY DIAGNOSIS:**		
Facility/Agency Requesting Placement (please include contact person, phone#, and fax to send determination):						
Current Location of the Individual:						
Type of Referral: □ Pre-admission; □ Resident Review; □ Extension Request						

TYPE OF EVALUATION

□ FACE TO FACE EVALUATION

□ DESK REVIEW	**REASON FOR DESK REVIEW** □ an independent assessment from the 1915i system pre-Bayou Health implementation (12/1/15): date of assessment_____*Please attach* □ a Bayou Health Behavioral Health Assessment – Adults post Bayou Health implementation (12/1/15): date of assessment_____*Please attach* □ a PASRR Level II evaluation is on file: date of assessment_____*Please attach*	**COMMENTS:**
□ NO EVALUATION COMPLETED, SENT BACK TO OBH	**REASON FOR SENDING BACK TO OBH** □ the individual **does not have a serious mental illness** □ **Categorical Decision** **Type of Categorical Decision (check if applicable):** □ Terminal illness □ Severe Physical illness □ Delirium □ Primary Dementia □ Convalescent Care □ Emergency/Protective Services □ Respite Services	**COMMENTS:**

DOCUMENTS REVIEWED/INDIVIDUAL INTERVIEWS

The following items were available/reviewed as part of this screening (attach all records reviewed):
□ Medical H&P □ Functional Assessment □ Psychiatric Evaluation □ Psychosocial Evaluation □ Comprehensive Medications
□ Psychological Testing Results □ Progress Notes □ Additional Labs or Consults: _____
□ Other _____

The following individuals were interviewed:
□ Individual □ Family/significant other _____(specify) □ Legal representative/Guardian/Conservator _____(specify)
□ Other agency for interdisciplinary coordination (specify) _____
□ Other _____

BEHAVIORAL HEALTH HISTORY

I. CHIEF COMPLAINT (Major symptoms, difficulties, and/or Issues as they relate to behavioral health –*in recipient's own words/quoted.*)

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II. PRESENTING PROBLEM/HISTORY OF PRESENT ILLNESS (Including recipient's reason for seeking services, precipitating factors, symptoms, behavioral and functioning impacts, onset/course of issues, *current behavioral health providers,* services sought and recipient expectation.)

CURRENT BEHAVIORAL HEALTH PROVIDER NAME:	**PHONE NUMBER:**

III. PAST PSYCHIATRIC HISTORY (First onset of illness, past diagnostic and treatment history, medications, hospitalizations-date, length, reasons, & facility):

Prior Outpatient Mental Health Treatment: □ No; □ Yes; Detail:	**Psychiatric Hospitalizations:** □ No; □ Yes; Detail:

Additional History/Comments:

IV. SUBSTANCE ABUSE/DEPENDENCE (Past use of primary, secondary & tertiary current substance, incl. type, freq, method & age of 1st use.)

Check any/all that apply in past 12 months:

□ Alcohol Use; □ Illegal Drug Use; □ Injected Drug Use ; □ Tobacco Product Use; □ Prescription Drugs Abuse; □ Non-Prescription (OTC) abuse; □ Alcohol and/or Drug Overdose; □ Alcohol and/or Drug Withdrawal; □ Problems caused by gambling; □ Trouble stopping any substance □ Other/Describe:

Substance Abuse Treatment History: □ None; □ Outpatient; □ Intensive Outpatient; □ Residential/Inpatient:; □ Detox; □ Other/Describe:

SUBSTANCE TYPE Include all use in last 30 days.	AGE OF 1ST USE	YEARS IN LIFETIME	DAYS IN PAST 30	DAYS SINCE LAST USE	AMOUNT	ROUTE OF ADMINISTRATION
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV
						□ Oral; □ Nasal; □ Smoking; □ Non-IV Injxn; □ IV

PHYSICAL/MEDICAL HISTORY

V. CURRENT MEDICAL CONDITIONS (Check all that apply)

Meets Medical Eligibility for NF placement as determined by the Level I Authority □ Yes □ No

□ Pregnant	Due date:		Prenatal care:		
□ None Reported	□ Congestive Heart Failure	□ Asthma	□ Seizure	□ Cancer	□ Underweight
□ High Blood Pressure	□ Stroke	□ Emphysema	□ Cirrhosis	□ Chronic Pain	□ Overweight
□ Heart Disease	□ Diabetes	□ Epilepsy	□ Digestive Problems	□ Thyroid Disease	□ Sexually Transmitted Dz.
□ Other/Describe:					

VI. CURRENT & PAST MEDICATIONS (Including non-psychotropic prescribed medications for last 12 months)

Medication Name	**Dose**	**Freq.**	**Route**	**Current**	**COMMENTS** (Reason Prescribed/Response/Side effects/Interactions, etc.)
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	
				□ Yes; □ No	

VII. ALLERGIES □ No Reported Drug or Food Allergies; □ Other/Describe:

VIII. PRIMARY CARE PHYSICIAN	**NAME**	**PHONE**	**FAX**

IX. ADDITIONAL MEDICAL HISTORY (Diagnosis, Pertinent injuries (head trauma), Illnesses; Hospitalizations, Surgery, labs values, status of conditions, etc. including the dates of onset)

X. LEGAL STATUS

Current Legal Status: □ None; □ Parole; □ Probation; □ Charges Pending; □ Court-Ordered Outpatient Treatment; □ AOT; □ Judicial; □ Other;
Comment/Detail:

Past Legal Status: □ None; □ DWI; □ Prior Arrests; □ Prior Incarcerations; □ Other;
Comment/Detail:

XI. FAMILY HISTORY (relationship status with relatives, family involvement in treatment, and living status of significant relatives):

Custodial Status: □ Independent Adult; □ Family Member; □ Gov't/Judicial; □ Other: (specify)	**Contact Info:** Name:	Relation	Phone #

Adverse Circumstances in Family of Origin: □ N/A; □ Poverty; □ Criminal Behavioral; □ Mental Illness; □ Substance Use; □ Abuse; □ Neglect; □ Domestic Violence; □ Violence; □ Trauma; □ Other/Describe:

Family Stress: □ Low Stress; □ Mildly Stressful; □ Moderately Stressful; □ Highly Stressful; □ Extremely Stressful □ Other/Describe:

Family Supports: □ Highly Supportive; □ Supportive; □ Limited Support; □ Minimal Support; □ No Support □ Other/Describe:

Additional Comments:

XII. TRAUMA HISTORY

History of Trauma: □ None; □ Experienced; □ Witnessed; □ Abuse; □ Neglect; □ Violence; □ Sexual Assault; □ Other/Describe:

XIII. LIVING SITUATION (Current status and functioning)

a. Primary Residence: □ Own Home; □ Apartment; □ Relative's Home; □ Group Home; □ Homeless; □ Nursing Facility; □ Other/Describe:
How long at current residence?
Family/Household Composition:
Source of meals/food: **Means of transportation:**
Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders.)

b. Needs -List what is needed to improve/maintain daily living situation (Ex. Transportation, ability to cook independently, housing subsidy, money in savings, care-giver resource assessment, etc.)

c. Preferences - Include things recipient feels will enhance his/her living situation.

d. Strengths -List assets, service options, and resources the person has to meet needs, including available housing options. (Ex. Knows area, applied for housing subsidy, can live with family member, unpaid care-giver resource available, etc.)

e. Abilities/Interests –Include recipient reported skills, aptitudes, capabilities, talents & competencies that might assist in maintaining or improving living situation.

XIV. LEARNING/WORKING AND FUNCTIONAL STATUS

a. Employment/Education/Rehabilitation Status:
Current source of income: **Estimated Monthly Income Amount:**
Highest Grade or Completed/Degree: **Military Status:** **Military Trauma:** □ No; □ Yes;
Difficulties with Reading/Writing: □ No; □ Yes; **Estimated Literacy Level:**
Current Employment Status: **Prior Employment Status:**
Assistive Devices utilized/required: □ No; □ Yes;
Additional Comments: (Include psychological and social adjustments made to disabilities and/or disorders.)

b. Current Status & Functioning (Assess ability to fulfill responsibilities, interact with others, capacity self-care, missed activities, work or school due to health, etc.)
Functional Status Impairment:

ADLs/IADLs	None	Minimal	Mild	Moderate	Serious	Extreme
Mobility						
Bathing						

Dressing						
Self-Feeding						
Personal hygiene & grooming						
Toilet hygiene						
Housework						
Meal Preparation						
Medication Management						
Managing Finances						
Shopping (groceries or clothing)						
Communication						
Transportation						

Comments:

c. Abilities/Interests - Include recipient reported skills, aptitudes, talents & competencies that may help maintain or improve socialization & community functioning.

CURRENT STATUS

XV. MENTAL STATUS EXAMINATION *(Circle or Check all that apply)*

a. GENERAL APPEARANCE □ Healthy; □As stated Age; □ Older Than Stated Age; □ Young-looking; □ Tattoos; □ Disheveled; □ Unkempt; □ Malodorous; □ Thin; □ Overweight; □Obese; □ Other/Describe:

b. BEHAVIOR & PSYCHOMOTOR ACTIVITY □ Normal; □ Overactive; □ Hypoactive; □ Catatonia; □ Tremor; □ Tics; □ Combative; □ Other/Describe:

c. ATTITUDE □ Optimal; □ Constructive; □ Motivated; □ Obstructive; □ Adversarial; □ Inaccessible; □ Cooperative; □ Seductive; □ Defensive; □ Hostile; □ Guarded; □ Apathetic; □ Evasive; □ Other/Explain:

d. SPEECH □ Normal; □ Spontaneous; □ Slow; □ Impoverished; □ Hesitant; □ Monotonous; □ Soft/Whispered; □ Mumbled; □ Rapid; □ Pressured; □ Verbose; □ Loud; □ Slurred; □ Impediment; □ Other/Describe:

e. MOOD □ Dysphoric; □ Euthymic; □ Expansive; □ Irritable; □ Labile; □ Elevated; □ Euphoric; □ Ecstatic; □ Depressed; □ Grief/mourning; □ Alexithymic; □ Elated; □ Hypomanic; □ Manic; □ Anxious; □ Tense; □ Other/Describe:

d. AFFECT □ Appropriate; □ Inappropriate; □ Blunted; □ Restricted; □ Flat; □ Labile; □ Tearful; □ Intense; □ Other/Describe:

g. PERCEPTUAL DISTURBANCES □ None; □ Hallucinations: □ Auditory; □ Visual; □ Olfactory; □ Tactile; □ Other/Describe:

h. THOUGHT PROCESS □ Logical/Coherent; □ Incomprehensible; □ Incoherent; □ Flight of Ideas; □ Loose Associations; □ Tangential; □ Circumstantial; □ Rambling; □ Evasive; □ Racing Thoughts; □ Perseveration; □ Thought Blocking; □ Concrete; □ Other/Describe:

i. THOUGHT CONTENT □ Preoccupations; □ Obsessions; □ Compulsions; □ Phobias; □ Delusions; □ Thought Broadcasting; □ Thought Insertion; □ Thought Withdrawal; □ Ideas of Reference; □ Ideas of Influence; □ Delusions; □ Other/Describe:

j. SUICIDAL/HOMICIDAL IDEATION □ Suicidal Thoughts; □ Suicidal Attempts; □ Suicidal Intent; □ Suicidal Plans; □ History of Self-Injurious Behavior □ Homicidal Thoughts; □ Homicidal Attempts; □ Homicidal Intent; □ Homicidal Plans; □ Other/Describe:

k. SENSORIUM/COGNITION □ Alert; □ Lethargic; □ Somnolent; □ Stuporous; **Oriented to:** □ Person; □ Place; □ Time; □ Situation; □ Normal Concentration; □ Impaired Concentration; □ Other/Describe:

l. MEMORY **Remote Memory:** □ Normal; □ Impaired; **Recent Memory:** □ Normal; □ Impaired; **Immediate Recall:** □ Normal; □ Impaired □ Other/Describe:

m. INTELLECTUAL FUNCTIONING (Estimate) □ Above Avg.; □ Normal/Avg.; □ Borderline; Mental Retardation: □ Mild; □ Moderate; □ Severe □ Other/Describe:

n. JUDGEMENT □ Critical Judgment Intact; □ Impaired Judgment; □ Other/Describe:

o. INSIGHT □ True Emotional Insight; □ Intellectual Insight; □ Some Awareness of Illness/symptoms; □ Impaired Insight; □ Denial; □ Other/Describe:

p. IMPULSE CONTROL □ Able to Resist Impulses; □ Recent Impulsive Behavior; □ Impaired Impulse Control; □ Compulsions; □ Other/Describe:

XVI. RISK ASSESSMENT: Assess potential risk of harm to self or others, including patterns of risk behavior and/or risk due to personality factors, substance use, criminogenic factors, exposure to elements, exploitation, abuse, neglect, suicidal or homicidal history, self-injury, psychosis, impulsiveness, etc.

a. Risk of Harm to Self: □ Prior Suicide Attempt; □ Stated Plan/Intent; □ Access to means (weapons, pills, etc.); □ Recent Loss; □ Presence of Behavioral Cues (isolation, giving away possessions, rapid mood swings, etc.); □ Family History of Suicide; □ Terminal Illness; □ Substance Abuse; □ Marked lack of support; □ Psychosis; □ Suicide of friend/acquaintance;

□ Other/Describe:

b. **Risk of Harm to Others**: □ Prior acts of violence; If yes, when was the most recent violent act? _____; □ Destruction of property; □ Arrests for violence; □ Access to means (weapons); □ Substance use; □ Physically abused as child; □ Was physically abusive as a child; □ Harms animals; □ Fire setting; □ Angry mood/agitation; □ Prior hospitalizations for danger to others; □ Psychosis/command hallucinations; If yes, is there a history of acting on any commands to harm others? □ Yes □ No; □ Other/Describe:

c. **Risk of Harm to Self or Others Rating:** *(From LOCUS Risk of Harm Evaluation Parameters.)* □ **Minimal;** □ **Low;** □ **Moderate;** □ **Serious;** □ **Extreme.**
As Evidenced By:

d. **Recipient Safety & Other Risk Factors:** □ Feels unsafe in current living environment; □ Feels currently being harmed/hurt/abused/threatened by someone; □ Engages in dangerous sexual behavior; □ Past involvement with Child or Adult Protective Services; □ Relapse/decompensation triggers; □ Other/Describe:

e. Describe recipient's **preferences and desires** for addressing risk factors, including any Mental Health Advance Directives or plan of response to periods of decompensation/relapse (Ex. Resources recipient feels comfortable reaching out to for assistance in a crisis.):

XVII. CULTURAL AND LANGUAGE PREFERENCES (Language, Customs/Values/Preferences)

a. Spiritual Beliefs/Preferences:

b. Cultural Beliefs/Preferences:

XVIII. PRINCIPAL DIAGNOSES (PROVIDE PRINCIPLE BEHAVIORAL, MEDICAL DIAGNOSES, AND DEVELOPMENTAL DISABILITY)

DIAGNOSIS	*SEVERITY, IF APPLICABLE*

IDENTIFIED NEEDS

1.

2.

3.

4.

5.

RECOMMENDED PLACEMENT

□ The individual has a serious mental illness and requires specialized services in an **acute setting**. (i.e. acute psychiatric hospital)

□ The individual has a serious mental illness and an **alternate setting** is recommended (i.e. community based treatment, adult residential facility) (specify setting)

□ The individual has a serious mental illness and meets criteria for **nursing home admission**
- □ **recommended on a long term basis**
- □ **recommended on a short term basis** (specify duration)

RECOMMENDED SPECIALIZED SERVICES (PROVIDED THROUGH MCO)

MH SERVICES:	□ ACT (21+)	□ CPST (21+)	□ PSR (21+)-Individual	□ PSR (21+)-Group	□ PSH
	□ Med Mgt	□ Outpt Therapy (Ind)	□ Outpt Therapy (Fam)	□ Outpt Therapy (Group)	
SA SERVICES:	□ Residential Tx	□ Halfway House	□ IOP	□ Ambulatory Detox	
	□ Outpt Therapy (Ind)	□ Outpt Therapy (Fam)	□ Outpt Therapy (Group)		

OTHER (WITH EXPLANATION)

RECOMMENDED LESSER SERVICES (PROVIDED OR ARRANGED BY THE NURSING FACILITY)

□ Med Mgt by the NF	□ Short term counseling to adjust to the nursing facility	□ Medication education	□ Speech Therapy	□ Training in ADLs	□ Training in independent living skills
□ Services for the visually/hearing impaired	□ Assistance in obtaining medical appliances and devices	□ Crisis intervention plan/safety plan	□ Structured leisure activities	□ Occupational therapy evaluation	□ Physical therapy evaluation

□ Referrals to other agencies or community programs (please specify)	□ Audiological evaluation	□ Dental evaluation	□ Vision evaluation	□ Interpretive services	□ A guardian / conservator for decisions regarding health and safety
□ Evaluation for a diagnosis of dementia (Alzheimer's or other organic mental disorder)	□ Ongoing evaluation of the effectiveness of current psychotropic medications to target symptoms.	□ Other (with explanation)			

ADDITIONAL SERVICE RECOMMENDATIONS:

INTERPRETATIVE SUMMARY OF FINDINGS/DECISION RATIONALE

Describe recipient's global preferences/hopes for recovery, recommended treatments/assessments, level of care, duration. Include clinical/central theme, co-occurring disabilities (to include mental health, substance use, and intellectual/developmental disabilities), environmental and personal supports/needs, justification for placement and service recommendations.

SIGNATURE

PRINTED NAME OF ASSESSOR	SIGNATURE	LICENSE NUMBER	DATE

BY SIGNING THIS DOCUMENT, I CERTIFY THAT I AM INDEPENDENT OF THE OFFICE OF BEHAVIORAL HEALTH MAKING THE DETERMINATIONS AND THAT I HAVE NO DIRECT OR INDIRECT AFFILIATION OR RELATIONSHIP WITH THE NURSING FACILITY.